

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0028530</u> Facility Name: <u>SHERWIN MANOR NURSING CENTER</u> Address: <u>7350 N. SHERIDAN ROAD</u> <u>CHICAGO</u> <u>60626</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>COOK</u> Telephone Number: <u>(773) 274-1000</u> Fax # <u>(773) 274-2353</u> IDPA ID Number: <u>36-3090453</u> Date of Initial License for Current Owners: <u>05/01/79</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div style="width: 30%;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div style="width: 30%;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	219	Skilled (SNF)	219	80,154	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	219	TOTALS	219	80,154	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			5,083	5,083	8
9	SNF/PED					9
10	ICF	29,633	2,639		32,272	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,633	2,639	5,083	37,355	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 46.60%)D. How many bed-hold days during this year were paid by Public Aid?
_____ (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/01/79J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/79 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 31 and days of care provided 4672Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **SHERWIN MANOR NURSING CENTI** # **0028530** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	297,749	41,492	12,166	351,407		351,407	0	351,407		1
2	Food Purchase		250,005		250,005		250,005	(789)	249,216		2
3	Housekeeping	61,880	48,262	0	110,142		110,142	0	110,142		3
4	Laundry	96,399	22,205	479	119,083		119,083	0	119,083		4
5	Heat and Other Utilities			155,116	155,116		155,116	0	155,116		5
6	Maintenance	35,725	13,872	49,912	99,509		99,509	7,557	107,066		6
7	Other (specify):*			10,562	10,562		10,562	0	10,562		7
8	TOTAL General Services	491,753	375,836	228,235	1,095,824		1,095,824	6,768	1,102,592		8
	B. Health Care and Programs										
9	Medical Director			10,400	10,400		10,400	0	10,400		9
10	Nursing and Medical Records	986,643	80,668	178,176	1,245,487		1,245,487	0	1,245,487		10
10a	Therapy	46,076		0	46,076		46,076	0	46,076		10a
11	Activities	63,866	7,203	0	71,069		71,069	0	71,069		11
12	Social Services	19,855		0	19,855		19,855	0	19,855		12
13	Nurse Aide Training			0				0			13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	1,116,440	87,871	188,576	1,392,887		1,392,887		1,392,887		16
	C. General Administration										
17	Administrative	425,949		0	425,949		425,949	0	425,949		17
18	Directors Fees			0				0			18
19	Professional Services			67,212	67,212		67,212	0	67,212		19
20	Dues, Fees, Subscriptions & Promotions			60,217	60,217		60,217	(8,104)	52,113		20
21	Clerical & General Office Expense	178,125	47,301	72,464	297,890		297,890	(10,391)	287,499		21
22	Employee Benefits & Payroll Taxes			406,796	406,796		406,796	(15,476)	391,320		22
23	Inservice Training & Education			5,036	5,036		5,036	0	5,036		23
24	Travel and Seminar			0				0			24
25	Other Admin. Staff Transportation			30,594	30,594		30,594	0	30,594		25
26	Insurance-Prop.Liab.Malpractice			116,627	116,627		116,627	0	116,627		26
27	Other (specify):*			0				0			27
28	TOTAL General Administration	604,074	47,301	758,946	1,410,321		1,410,321	(33,971)	1,376,350		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,212,267	511,008	1,175,757	3,899,032		3,899,032	(27,203)	3,871,829		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number SHERWIN MANOR NURSING CENTI # 0028530 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			167,199	167,199		167,199	(10,601)	156,598		30
31	Amortization of Pre-Op. & Org.			3,840	3,840		3,840	0	3,840		31
32	Interest			174,139	174,139		174,139	(9,511)	164,628		32
33	Real Estate Taxes			266,780	266,780		266,780	0	266,780		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles							0			35
36	Other (specify):*							0			36
37	TOTAL Ownership			611,958	611,958		611,958	(20,112)	591,846		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		53,622	38,692	92,314		92,314	0	92,314		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			120,232	120,232		120,232	0	120,232		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		53,622	158,924	212,546		212,546		212,546		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,212,267	564,630	1,946,639	4,723,536	0	4,723,536	(47,315)	4,676,221		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **SHERWIN MANOR NURSING CENTER**

0028530

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(10,601)	30		9
10	Interest and Other Investment Income	(9,511)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(789)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(55)	20		17
18	Fines and Penalties	(10,391)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance	(15,476)	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(7,049)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	7,557	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,315)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	0	SCHED	34
35	Other- Attach Schedule	0	ATTACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (47,315)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb SHERWIN MANOR NURSING CENTER

0028530 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	(789)	0	0	0	0	0	0	0	0	0	0	(789) 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	7,557	0	0	0	0	0	0	0	0	0	0	7,557 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	6,768	0	0	0	0	0	0	0	0	0	0	6,768 8
B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	(8,104)	0	0	0	0	0	0	0	0	0	0	(8,104) 20
21	Clerical & General Office Expenses	(10,391)	0	0	0	0	0	0	0	0	0	0	(10,391) 21
22	Employee Benefits & Payroll Taxes	(15,476)	0	0	0	0	0	0	0	0	0	0	(15,476) 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	(33,971)	0	0	0	0	0	0	0	0	0	0	(33,971) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,203)	0	0	0	0	0	0	0	0	0	0	(27,203) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number: SHERWIN MANOR NURSING CENTER # 0028530 Report Period Beginning: 01/01/2000 Ending: 12/31/2000 Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

**Print Summary
B**

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(10,601)	0	0	0	0	0	0	0	0	0	0	(10,601)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,511)	0	0	0	0	0	0	0	0	0	0	(9,511)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,112)	0	0	0	0	0	0	0	0	0	0	(20,112)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(47,315)	0	0	0	0	0	0	0	0	0	0	(47,315)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: **SHERWIN MANOR NURSING CENTER**

STATE OF ILLINOIS
ID: **000000**

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

Page: **6**

VI. RELATED PARTIES

Show Pgs 6A thru 6

Show Pgs 6B thru 6

Hide Pgs 6A thru 6B

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS			RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	City	Name	City	Name	Type of Business	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ Yes

☒ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Schedule V Line	Item	Amount	Name of Related Organization	% of Ownership	Operating Costs of Related Organization	Reference: Related Organization Case C Number, if applicable
1	V					
2	V					
3	V					
4	V					
5	V					
6	V					
7	V					
8	V					
9	V					
10	V					
11	V					
12	V					
13	V					
14	V					
15	V					
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125	V					
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127	V					
128	V					
129	V					
130	V					
131	V					
132	V					
133	V					
134	V					
135	V					
136	V					
137	V					
138	V					
139	V					
140	V					
141	V					
142	V					
143	V					
144	V					
145	V					
146	V					
147	V					
148	V					
149	V					
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151	V					
152	V					
153	V					
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162	V					
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164	V					
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170	V					
171	V					
172	V					
173	V					
174	V					
175	V					
176	V					
177	V					
178	V					
179	V					
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181	V					
182	V					
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268	V					
269	V					
270	V					
271	V					
272	V					
273	V					
274	V					
275	V					
276	V					
277	V					
278	V					
279	V					
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281	V					
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287	V					
288	V					
289	V					
290	V					
291	V					
292	V					
293	V					
294	V					
295	V					
296	V					
297	V					
298	V					
299	V					
300	V					
301	V					
302	V					
303	V					
304	V					
305	V					
306	V					
307	V					
308	V					
309	V					
310	V					
311	V					
312	V					
313	V					
314	V					
315	V					
316	V					
31						

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	15
16	V						16
17	V						17
18	V						18
19	V						19
20	V						20
21	V						21
22	V						22
23	V						23
24	V						24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$		\$	\$ *	39

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0028530 Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0028530 Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Compensation Received From Other Nursing Homes*	Average Hours Per Work	Compensation Included in Costs for this Reporting Period**	Schedule V. Line & Column Reference		
							Week Devoted to this Facility and % of Total Work Week				
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	JOSEPH OSINA	ADMINISTRATOR			24.1	40	100.00	SALARY	\$ 165,477	17-1	1
2	ABE OSINA	ASST. ADMIN.			24.7	60	100.00	SALARY	260,472	17-1	2
3	ROSANNE OSINA	FOOD SERV. SUP.			0	40	100.00	SALARY	76,028	1-1	3
4	SARAH OSINA	PURCHASING			0	40	100.00	SALARY	51,005	21-1	4
5	DOV OSINA	CLERICAL			24.6	40	100.00	SALARY	15,600	21-1	5
6	DEVORA OSINA	CLERICAL			2.6	40	100.00	SALARY	10,646	21-1	6
7	HINDA OSINA	DIETARY			2.6	40	100.00	SALARY	12,628	1-1	7
8	CHAYA OSINA	MED. RECORD			2.6	25	100.00	SALARY	2,456	10-1	8
9	YEHUDA OSINA	DIETARY			2.6		100.00	SALARY	595	1-1	9
10	DEVORAH OSINA	DIETARY			2.6	15	100.00	SALARY	96	1-1	10
11	PESACH OSINA	CLERICAL			2.6	40	100.00	SALARY	17,160	21-1	11
12	MORDECHAI OSINA	MAINTENANCE			2.6	18	100.00	SALARY	8,382	6-3	12
13								TOTAL	\$ 620,545		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000Ending: 1/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Print Preview

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LASALLE BANK		X	MORTGAGE	\$19,324.00	11/27/96	\$ 2,300,000	\$ 2,098,434	11/30/01		\$ 174,139	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$19,324.00		\$ 2,300,000	\$ 2,098,434			\$ 174,139	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,300,000	\$ 2,098,434			\$ 174,139	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number: **SHERWIN MANOR NURSING CENTER**# **0028530**

Report Period Beginning:

01/01/2000

Ending:

12/31/2000**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	293,999	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	266,487	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(27,512)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	294,292	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	266,780	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	1996	1997	1998	1999		
	270,758	277,420	263,608	268,288	266,487	8	9
						10	11
						12	

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,334 B. General Construction Type: Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITIES	47,313		\$ 123,000	1
2					2
3	TOTALS	47,313		\$ 123,000	3

Print Preview

**IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.**

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0028530

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	219		1979	1979	\$ 2,919,751	\$ 88,477	33	\$ 88,477	\$	\$ 1,909,542	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENTS			1984	9,000		15			9,000	9
10	LEASEHOLD IMPROVEMENTS			1991	28,119	893	31.5	893		8,669	10
11	LEASEHOLD IMPROVEMENTS			1992	23,487	746	31.5	746		6,092	11
12	LEASEHOLD IMPROVEMENTS			1993	11,285	358	31.5	358		2,776	12
13	LEASEHOLD IMPROVEMENTS			1993	5,825	149	39	149		1,115	13
14	LEASEHOLD IMPROVEMENTS			1994	34,686	889	39	889		5,520	14
15	ELECTRIC OUTLETS			1995	843	22	39	22		139	15
16	WHEELCHAIR RAMP			1995	4,800	123	39	123		730	16
17	VARIOUS ELECTRICAL WORK			1995	19,870	509	39	509		2,815	17
18	REPLACE STACK, VENT, CAST IRON DRAIN			1996	2,202	56	39	56		269	18
19	INSTALL NEW TOWER MOTOR, RAIN SHIELD, HEATER			1996	1,675	43	39	43		206	19
20	INSTALL CEILING FAN, NEW FIXTURE IN BATHROOM			1996	1,008	26	39	26		125	20
21	CONNECT GAS FOR KITCHEN COOKING EQUIPMENT			1996	1,200	31	39	31		148	21
22	INSTALL FLUORESCENT FIXTURES IN RESIDENT ROOM			1996	56,385	1,446	39	1,446		6,950	22
23	REMODELING			1997	112,292	2,879	39	2,879		9,959	23
24	REPLACEMENT HOT WATER HEATERS			1998	25,065	643	39	643		1,581	24
25	FURNISH & INSTALL NEW FIRE SMOKE DUMPERS			1998	7,234	185	39	185		455	25
26	NEW SHOWER VALVE, SOIL PIPE			1998	1,739	45	39	45		110	26
27	REPAIR AIR CONDITIONING			1998	11,080	284	39	284		699	27
28	INSTALL NEW RECESSED CANS, FIXTURES ILLUMINATI			1998	7,249	186	39	186		457	28
29	REPLACEMENT COOLING TOWER			1999	25,622	657	39	657		959	29
30	ELECTRICAL WORK -FRONT OF BUILDING, OFFICE ARE			1999	17,362	445	39	445		649	30
31	CORRIDOR SYSTEM			1999	3,311	85	39	85		124	31
32	WATER COOLER			1999	2,414	62	39	62		90	32
33	LAUNDRY DOMESTIC HOT WATER HEATER			2000	11,789	139	39	139		139	33
34	INSTALL NEW FENCE			2000	7,840	92	15	523	431	523	34
35	FLUORESCENT LIGHTING			2000	13,040	154	39	154		154	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 99,624		\$ 100,055	\$ 431	\$ 1,969,995	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe SHERWIN MANOR NURSING CENTER

0028530

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	INSTALLED SMOKERS EXHAUST SYSTEM			2000	6,748	79	39	79		79	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 79		\$ 79	\$	\$ 79	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe SHERWIN MANOR NURSING CENTER

0028530

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0028530

Report Period Beginning:

Page 12C

01/01/2000(Ending: 12/31/2000

Facility Name & ID Numbe SHERWIN MANOR NURSING CENTER

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12D

Facility Name & ID Numbe SHERWIN MANOR NURSING CENTER

0028530

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0028530 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 475,556	\$ 60,628	\$ 46,825	\$ (13,803)	7-10 YR	\$ 231,306	37
38	Current Year Purchases	26,650	3,808	1,333	(2,475)	10 YR	1,333	38
39	Fully Depreciated Assets	403,981					403,981	39
40								40
41	TOTALS	\$ 906,187	\$ 64,436	\$ 48,158	\$ (16,278)		\$ 636,620	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		1992 LEXUS	1992	\$ 0	\$ 0	\$ 0			\$ 27,367	42
43		1994 FORD WAGON	1994	24,887	0	0			24,887	43
44		2001 OLDS AURORA	2000	41,529	3,060	8,306	5,246	5	8,306	44
45		1995 OLDS AURORA	1995	33,822					28,430	45
46	TOTALS			\$ 100,238	\$ 3,060	\$ 8,306	\$ 5,246		\$ 88,990	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 167,199	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 156,598	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (10,601)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,695,684	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm: \$ N/A Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			<u>N/A</u>		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number SHERWIN MANOR NURSING CENTER

#

0028530

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.**THE FACILITY HIRES ONLY TRAINED AIDES.**2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.**Print Preview**

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ies.

Facility Name & ID Number SHERWIN MANOR NURSING CENTER# 0028530 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 4,037	\$		\$ 4,037	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,077			4,077	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			30,578			30,578	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				53,622		53,622	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$		\$ 38,692	\$ 53,622		\$ 92,314	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number SHERWIN MANOR NURSING CENTER

0028530

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 396,808	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	682,727		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,212		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,163,747	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	123,000		13
14	Buildings, at Historical Cost	2,919,751		14
15	Leasehold Improvements, at Historical Cost	453,170		15
16	Equipment, at Historical Cost	972,603		16
17	Accumulated Depreciation (book methods)	(2,748,169)		17
18	Deferred Charges	19,189		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort of Def MTG Costs	(15,658)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,723,886	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,887,633	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,298	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	19,853		29
30	Accrued Salaries Payable	110,351		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,169		31
32	Accrued Real Estate Taxes(Sch.IX-B)	294,292		32
33	Accrued Interest Payable	14,564		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,089		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 742,616	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,098,434		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,098,434	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,841,050	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 46,583	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,887,633	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 19,622	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 19,621	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	176,962	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 26,962	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 46,583	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number SHERWIN MANOR NURSING CENTER # 0028530 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,893,581	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,893,581	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(1,449)	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ (1,449)	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	323	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 323	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,511	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,511	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PARKING RECEIPTS	2,295	28
28a	VENDING COMMISSIONS (NET OF COST)	(674)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,621	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,903,587	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,095,824	31
32	Health Care	1,392,887	32
33	General Administration	1,410,321	33
B. Capital Expense			
34	Ownership	611,958	34
C. Ancillary Expense			
35	Special Cost Centers	92,314	35
36	Provider Participation Fee	120,232	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,723,536	40
41	Income before Income Taxes (line 30 minus line 40)**	180,051	41
42	Income Taxes	3,089	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 176,962	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	3,767	4,289	\$ 176,594	\$ 41.17	1
2 Assistant Director of Nursing					2
3 Registered Nurses	4,056	4,493	86,774	19.31	3
4 Licensed Practical Nurses	20,886	22,871	403,688	17.65	4
5 Nurse Aides & Orderlies	33,041	34,279	275,500	8.04	5
6 Nurse Aide Trainees					6
7 Licensed Therapist	3,264	3,515	46,076	13.11	7
8 Rehab/Therapy Aides					8
9 Activity Director	1,987	1,986	36,669	18.46	9
10 Activity Assistants	3,455	3,580	27,197	7.60	10
11 Social Service Workers	2,068	2,189	19,855	9.07	11
12 Dietician					12
13 Food Service Supervisor	2,091	2,341	76,028	32.48	13
14 Head Cook	1,938	2,140	27,109	12.67	14
15 Cook Helpers/Assistants	23,422	25,172	194,612	7.73	15
16 Dishwashers					16
17 Maintenance Workers	2,858	3,175	35,725	11.25	17
18 Housekeepers	8,766	9,207	61,880	6.72	18
19 Laundry	10,439	11,274	96,399	8.55	19
20 Administrator	2,091	2,341	165,477	70.69	20
21 Assistant Administrator	2,171	2,426	260,472	107.37	21
22 Other Administrative					22
23 Office Manager					23
24 Clerical	12,365	13,224	178,125	13.47	24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)					28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)					30
31 Medical Records	164	182	2,456	13.49	31
32 Other Health Care(specify)					32
33 Other(specify WARD CLERK	2,936	3,262	41,631	12.76	33
34 TOTAL (lines 1 - 33)	141,765	151,946	\$ 2,212,267 *	\$ 14.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	M	\$ 8,945	1-3	35
36 Medical Director	O	10,400	9-3	36
37 Medical Records Consultant	N	4,032	10-3	37
38 Nurse Consultant	T	0	10-3	38
39 Pharmacist Consultant	H	6,190	10-3	39
40 Physical Therapy Consultant	L	0	10a-3	40
41 Occupational Therapy Consultant	Y	0	10a-3	41
42 Respiratory Therapy Consultant		0	10a-3	42
43 Speech Therapy Consultant	F	0	10a-3	43
44 Activity Consultant	E	0	11-3	44
45 Social Service Consultant	E	0	12-3	45
46 Other(specify)	S			46
47 PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48				48
49 TOTAL (lines 35 - 48)		\$ 29,567		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses	1,936	\$ 44,440	10-3	50
51 Licensed Practical Nurses			10-3	51
52 Nurse Aides	5,596	117,250	10-3	52
53 TOTAL (lines 50 - 52)	7,532	\$ 161,690		53

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****See instructions.**